

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09361

9383

CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Rural.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Rural.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>#1- Bush River area.</u>		d. STREET ADDRESS <u>Bush River area</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Nelson</u> Last <u>Boyer</u>		4. DATE OF DEATH Month <u>9</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/23/1898</u>
9. AGE (In years lost birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>19</u> Min.	11. IF UNDER 24 HRS. Months <u>5</u> Days <u>5</u> Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Frederick Nelson</u>		14. MOTHER'S MAIDEN NAME <u>Effie L. Michael</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Oliver P. Boyer Sr.</u>		Address <u>Aberdeen #1-2nd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hematemesis</u> DUE TO <u>Carcinoma of Pancreas c metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>157X</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>6 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1947</u> , 19 <u>9-5-56</u> to <u>9-5-56</u> , that I last saw the deceased alive on <u>9-4-56</u> , 19 <u>9-4-56</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter P. Rodman</u> M.D.		ADDRESS (Street, city or town, state) <u>Aberdeen, Md.</u> DATE SIGNED <u>Sept 7-56</u>	
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/7/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spesutie cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Perryman Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Farring</u>		ADDRESS <u>Aberdeen rd.</u>	
24a. REC'D BY REGISTRAR <u>Sept 7-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mellie R. Perry</u>	

BUREAU V. 3

SEP 10 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9367 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09362

Reg. Dist. No. 185-

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Hartford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Hartford, Grace</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institutions: Residence before admission) a. STATE <u>PENN</u> b. COUNTY <u>Polmeroy</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25X-3</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>George T. Coldwell</u> First Middle Last				<b>4. DATE OF DEATH</b> September 13 1956 Month Day Year			
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Oct 2, 1882</u>	
<b>9. AGE</b> (In years last birthday) <u>73</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Electrician</u>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Unknown</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Civil G. Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Rev. M. Caldwell</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Jane Brown</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Unknown</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>		<b>17. INFORMANT</b> <u>Parents Funeral Home</u> Address <u>Coatsville, Pa.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Gerald C Palmer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				<b>DATE SIGNED</b> <u>9/13/56</u>			
<b>EXAMINER'S NAME (Type)</b> <u>Gerald C Palmer M.D.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>9/17/56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Chester Co. Pa.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Rev. White Funeral Home</u> ADDRESS <u>103 E. Lincoln Hwy, Coatsville, Pa.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>DATE 9-16-56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>G. H. Lewis M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. E.

SEP 18 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9384 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09363

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Hartford</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			c. LENGTH OF STAY IN 1b <u>92 years</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RD 2</u>				d. STREET ADDRESS <u>RD 2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>William</u> First <u>E</u> Middle <u>Cooper</u> Last				<b>4. DATE OF DEATH</b> Month <u>September</u> Day <u>10</u> Year <u>1956</u>											
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>E</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Feb. 26, 1864</u>		<b>9. AGE</b> (In years last birthday) <u>92</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Owner</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Nathan E. Cooper</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> <u>William E. Cooper, Bel Air, R.D.#2</u> Address <u>Md.</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____												INTERVAL BETWEEN ONSET AND DEATH <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
<b>ACTUAL SIGNATURE</b> <u>Gerald C Palmer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>												DATE SIGNED			
<b>EXAMINER'S NAME (Type)</b> <u>Gerald C Palmer, M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>												<u>9/10/56</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>Feb 13, 1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Asbury</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>Churchville, Hartford, Md</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Howard K. McComas &amp; Son</u> ADDRESS <u>Abingdon, Md.,</u>						<b>24a. REC'D BY REGISTRAR</b> DATE <u>9-15-56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Puella Lowndes</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. COOPER		AGE 35		SEX Male		RACE White	
DATE OF DEATH September 18, 1956		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore	
OCCUPATION None		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		MEDICAL HISTORY None	
SIGNATURE OF EXAMINER J. H. [Signature]		DATE September 18, 1956		PLACE Baltimore		COUNTY Baltimore	

RECEIVED  
SEP 18 1956  
BUREAU V. B.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom of the certificate may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9385

## CERTIFICATE OF DEATH

09364

Reg. Dist. No. 180

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		STATE <u>MARYLAND</u>		COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL JOPPA</u>		LENGTH OF STAY (in this place) <u>2 YEARS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL JOPPA</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 366 RFD #1</u>				STREET ADDRESS (If rural give location) <u>Box 366 RFD #1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>SARAH ELIZABETH DICKINSON</u>				<b>4. DATE OF DEATH</b> (Month) <u>SEPT.</u> (Day) <u>18</u> (Year) <u>19 56</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JULY 23, 1876</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>DETER LAWRENCE</u>				14. MOTHER'S MAIDEN NAME <u>MARY FULLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>224-14-6419B</u>		17. INFORMANT & ADDRESS <u>EVELYN MYERS, JOPPA, Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Arterio Sclerotic</u>						<u>Over 4 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Cardiovascular disease with</u>							
<u>Cardiac Hypertrophy.</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) _____		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
<b>22. I hereby certify</b> that I attended the deceased from <u>October 19 53</u> to <u>Sept 19 56</u> , that I last saw the deceased alive on <u>Sept 18, 19 56</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Philip W. Khuman</u>				ADDRESS (Street, city, town, state) <u>M.D. 307 Hickory, Bel Air, Md</u>		DATE SIGNED <u>Sept 18 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 22 56</u>		NAME OF CEMETERY OR CREMATORY <u>Leemont</u>		LOCATION (City, town, or county) (State) <u>Danville Va</u>	
24. REC'D BY REGISTRAR <u>SEP 21 1956</u>		REGISTRAR'S SIGNATURE <u>Norma G. Moore</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Archer</u>		ADDRESS <u>Benson Md</u>	

**BUREAU V.**

SEP 21 1956

RECEIVED



9386

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Varrettsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Varrettsville</u>	
c. LENGTH OF STAY IN 1b <u>52 yrs</u>		d. STREET ADDRESS <u>—</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY ANN EMRICK</u>		4. DATE OF DEATH <u>Sept 23 - 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 15<sup>th</sup> 1888</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Fawn Grove Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FELIX H. KUNKEL</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE THOMPSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Wm M. Emrick White Harford</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA RT LUNG</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTIO SCLEROTIC HT. Disease</u> DUE TO (c) <u>GENERALIZED ARTERIO SCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>10 years</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PSYCHOSIS - TYPE NOT KNOWN - PROBABLY PARANOID</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 22, 1957</u> , to <u>Sept 23, 1957</u> , that I last saw the deceased alive on <u>Sept 23, 1957</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. James Thompson</u> M.D.		ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>9/25/57</u>	
PHYSICIAN'S NAME (Type) <u>Baruch James Thompson, Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 26-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fawn Grove Meth.</u>	22d. LOCATION (City, town, or county) (State) <u>Fawn Grove Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin Skurtz</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>	
ADDRESS <u>Varrettsville</u>		DATE <u>9-27-56</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Full Name of Deceased

Thurstonville 1955

Age

10 10

Female

GATHERINE THOMPSON

Wife of Frank White

BUREAU V. S.

OCT 1 1956

RECEIVED

WET

9368

## CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>Harford Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>				c. LENGTH OF STAY IN 1b <u>13 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>none</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lydia Alice Friend</u>				4. DATE OF DEATH <u>9/11/56</u> Month <u>9</u> Day <u>11</u> Year <u>19</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/26/1881</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Haydon, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. Van Rieck</u>				14. MOTHER'S MAIDEN NAME <u>Phoebe Manges</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>John W. Racy</u> Address <u>141 Wilson, Harford</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus &amp; coma</u> DUE TO (c) <u>Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 days</u> <u>1 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June</u> , 19 <u>53</u> , to <u>Sept</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 11</u> , 19 <u>56</u> , and that death occurred at <u>7:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank Wolbert MD.</u> M.D.				ADDRESS (Street, city or town, state) <u>HARFORD DE GRACE MD</u> DATE SIGNED <u>9/11/56</u>			
PHYSICIAN'S NAME (Type) <u>FRANK WOLBERT MD.</u>				DATE <u>Sept. 11 - 56</u> G. L. Lewis M.D.			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/14/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George</u>		22d. LOCATION (City, town, or county) (State) <u>Ryanston, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond J. M. Harford</u>				ADDRESS <u>Harford</u>		24a. REC'D BY REGISTRAR <u>DATE Sept. 11 - 56</u>	
				24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 13 1956

RECEIVED

1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9369

## CERTIFICATE OF DEATH

09367

Reg. Dist. No. 185

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>		LENGTH OF STAY (in this place) <i>25 yrs.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>		TOWN <i>Harre de Grace</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>552 St. Clair St.</i>				STREET ADDRESS (If rural give location) <i>552 St. Clair St.</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Arthur</i> (First) <i>Hawkins</i> (Middle) <i>Hawkins</i> (Last)				<b>4. DATE OF DEATH</b> (Month) <i>9</i> (Day) <i>26</i> (Year) <i>1956</i>			
<b>5. SEX</b> <i>Male</i>	<b>6. COLOR OR RACE</b> <i>Negro</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>married</i>	<b>8. DATE OF BIRTH</b> <i>10-3-1885</i>		<b>9. AGE last birthday</b> <i>70</i> yrs.	<b>IF UNDER 1 YEAR</b> Months <i>11</i> Days <i>26</i> <b>IF UNDER 24 HRS.</b> Hours <i></i> Min. <i></i>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Retired Laborer</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Government</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Maryland</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i>	
<b>13. FATHER'S NAME</b> <i>Richard Hawkins</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Eliza Floyd</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <i>213-14-4044</i>		<b>17. INFORMANT &amp; ADDRESS</b> <i>Mo. Eva Hawkins 552 St. Clair St. Harre de Grace, Md.</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>592X IMMEDIATE CAUSE (A)</b> <i>Pulmonary Edema</i>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>1 day</i>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <i>Myocardial Failure</i>						<i>1 month</i>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <i>Chronic Nephritis with Uremia</i>						<i>1 month</i>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b> (County) (State)			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <i>June</i> , 19 <i>56</i> , to <i>Sept-26</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Sept-26</i> , 19 <i>56</i> , and that death occurred at <i>7:45 P.</i> M., from the causes and on the date stated above.							
<b>SIGNATURE</b> <i>John Unbehth M.D.</i>				<b>ADDRESS</b> (Street, city, town, state) <i>Harre de Grace Maryland</i>		<b>DATE SIGNED</b> <i>9/27/56</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>		<b>DATE THEREOF</b> <i>Sept. 30, 1956</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>St. James Cemetery</i>		<b>LOCATION (City, town, or county)</b> <i>Harre de Grace, Md.</i>	
<b>24. REC'D BY REGISTRAR</b> <i>Sept 28-56</i>		<b>REGISTRAR'S SIGNATURE</b> <i>G. H. Lewis M.D.</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Elmer E. Bullock</i>		<b>ADDRESS</b> <i>Harre de Grace</i>	

VS AISC 1-55 10M



# CERTIFICATE OF DEATH

0003

1956

1. NAME OF DECEASED

MARY ANN  
MARTIN

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. MEDICAL CERTIFICATION

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

BUREAU V. 2

OCT 1 1956

RECEIVED

INSTRUCTIONS

1. Fill in the name of the deceased in full, including the name of the mother, if known.

2. Fill in the date of death in full, including the day, month, and year.

3. Fill in the place of death in full, including the street, city, county, and state.

4. Fill in the time of death in full, including the hour, minute, and second.

5. Fill in the place of birth in full, including the street, city, county, and state.

6. Fill in the occupation of the deceased in full.

7. Fill in the cause of death in full, including the name of the disease, the organ affected, and the mode of action.

8. Fill in the manner of death in full, including the name of the disease, the organ affected, and the mode of action.

9. Fill in the medical certification in full, including the name of the physician, the date, and the place.

10. Fill in the signature of the physician in full.

11. Fill in the signature of the registrar in full.

12. Fill in the signature of the witnesses in full.

13. Fill in the signature of the coroner in full.

14. Fill in the signature of the jury in full.

15. Fill in the signature of the judge in full.

16. Fill in the signature of the clerk in full.

17. Fill in the signature of the sheriff in full.

18. Fill in the signature of the deputy sheriff in full.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10351	
9370 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 185-	
1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>			c. LENGTH OF STAY IN 1b <b>13 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Whiteford</b>			d. STREET ADDRESS <b>X</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hosp.</b>					d. STREET ADDRESS <b>1</b>						
3. NAME OF DECEASED (Type or print) First <b>PATRICK</b> Middle <b>FRANCES</b> Last <b>HUSHON</b>					4. DATE OF DEATH Month <b>Sept.</b> Day <b>18</b> Year <b>19 56</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-29-1873</b>		9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MERCHANT GENERAL</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Patrick Hushon</b>					14. MOTHER'S MAIDEN NAME <b>MATILDA Mc MILLIAN</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-18-9341</b>		17. INFORMANT <b>Joseph Hushon Delta PWH, Pa.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage accompanying contusion of the scalp</b> DUE TO <b>812X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pedestrian struck by auto</b>								
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>9/15/56</b> 19 p. m. <b>9</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) <b>Whiteford</b>		(County) <b>Maryland</b> (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>R S Fisher</b>					M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED <b>9/18/56</b>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>9-20-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST. MARY'S</b>			22d. LOCATION (City, town, or county) (State) <b>PPLESVILLE, HARFORD CO., Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth W. Ashburn</b>					ADDRESS <b>Stewartstown Pa</b>		24a. REC'D BY REGISTRAR <b>DATE Sept 20-56</b>		24b. REGISTRAR'S SIGNATURE <b>G. L. Lauer</b>		

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
[Illegible]		Male		[Illegible]		White		[Illegible]		[Illegible]	
Residence		Occupation		Cause of Death		Manner of Death		Time of Death		Signature of Examiner	
[Illegible]		[Illegible]		[Illegible]		[Illegible]		[Illegible]		[Illegible]	
Medical History		Previous Illnesses		Injury		Toxicology		Autopsy		Remarks	
[Illegible]		[Illegible]		[Illegible]		[Illegible]		[Illegible]		[Illegible]	

BUREAU V.

SEP 21 1956

RECEIVED

General S. [Illegible], M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09368

## CERTIFICATE OF DEATH

Reg. Dist. No.

185

9371

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Jones</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-14-1895</u>	
9. AGE (In years lost birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler Fireman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Federal Housing</u>			
11. BIRTHPLACE (State or foreign country) <u>Butterworth, Va.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u>231-01-6403</u>			
17. INFORMANT Address <u>Mrs. Myers - Federal Housing, Edgewood, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Arterio sclerotic Heart disease</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.0</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 mins.</u> <u>21 mos.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12/1</u> , 19 <u>54</u> , to <u>9/26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/26</u> , 19 <u>56</u> , and that death occurred at <u>10:05 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George T. Stansbury</u> M.D.				ADDRESS (Street, city or town, state) <u>569 Revolution St., Harre de Grace, Md.</u>			
DATE SIGNED <u>9/26/56</u>							
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>				PLACE OF DEATH <u>Harre de Grace, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>October 1, 1956</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer E. Bullock</u>				ADDRESS <u>Harre de Grace, Md.</u>			
24a. REC'D. BY REGISTRAR <u>G. H. Lewis</u>				24b. REGISTRAR'S SIGNATURE <u>G. H. Lewis</u>			
DATE <u>Oct. 1 - 56</u>							

# CERTIFICATE OF DEATH

BUREAU V. 3.

OCT 2 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09369

9372

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>87X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>7314 Main Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ann</u> Last <u>Lamm</u>		4. DATE OF DEATH Month <u>September</u> Day <u>3</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-9-1882</u>
9. AGE (In years last birthday) yrs. <u>73</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Port Deposit, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George A. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Martha (Hall)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Mrs. Florence L. Gibson</u>		Address <u>Port Deposit, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per time for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>S.D. hemmings cause undetermined</u> DUE TO <u>578x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 2, 1956</u> to <u>Aug 3, 1956</u> that I last saw the deceased alive on <u>Aug 3, 1956</u> , and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm K. Brendle</u> M.D.		ADDRESS (Street, city or town, state) <u>Havre de Grace, Md. 9-3-56</u>	
PHYSICIAN'S NAME (Type) <u>Wm K. Brendle</u> M.D.		<u>Havre de Grace, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-6-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson &amp; Son</u>		ADDRESS <u>Perryville, Md.</u>	
24a. REC'D BY REGISTRAR <u>9-6-56</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis m. el.</u>	

CERTIFICATE OF DEATH

Form No. 10

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9 Film 0207 11-26-56 et

09370

9373

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <i>Harford</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Harford</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Havre de Grace</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Havre de Grace</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>519 Alliance St.</i>		STREET ADDRESS (If rural give location) <i>417 Lafayette St.</i>	
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Angeline</i> (First) <i>Leggar</i> (Middle) <i>Leggar</i> (Last)		<b>4. DATE OF DEATH</b> (Month) <i>9</i> (Day) <i>29</i> (Year) <i>1956</i>	
<b>5. SEX</b> <i>Female</i>	<b>6. COLOR OR RACE</b> <i>Negro</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>married</i>	<b>8. DATE OF BIRTH</b> <i>Unknown</i>
<b>9. AGE last birthday</b> <i>70</i> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <i>0</i> Days <i>0</i>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <i>Maryland</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U. S. A.</i>	
<b>13. FATHER'S NAME</b> <i>Sidney Butler</i>		<b>14. MOTHER'S MAIDEN NAME</b> <i>Elizabeth (unknown)</i>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>no</i>		<b>16. SOCIAL SECURITY NO.</b> <i>none</i>	
<b>17. INFORMANT &amp; ADDRESS</b> <i>Mr. Robert O. Harris - Havre de Grace</i>		<b>18. MEDICAL CERTIFICATION</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>420.0 IMMEDIATE CAUSE</b> (A) <i>Uremia</i>			
<b>ANTECEDENT CAUSE(S)</b> (B) <i>Arteriosclerotic Heart disease</i>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> (C) <i>Arteriosclerotic Heart disease</i>			
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)</b>	
<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)</b>		<b>21e. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from <i>4/10</i>, 19 <i>56</i>, to <i>9/29</i>, 19 <i>56</i>, that I last saw the deceased alive on <i>9/29</i>, 19 <i>56</i>, and that death occurred at <i>11:45 A.M.</i> from the causes and on the date stated above.</b>			
<b>SIGNATURE</b> <i>George T. Stansbury</i>		<b>DATE SIGNED</b> <i>9/29/56</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>		<b>24. REC'D BY REGISTRAR</b>	
<b>DATE THEREOF</b> <i>10-2-56</i>		<b>REGISTRAR'S SIGNATURE</b> <i>A. L. Lewis m.d.</i>	
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Otelia J. Bullock</i>		<b>ADDRESS</b> <i>Havre de Grace, Md.</i>	
<b>DATE</b> <i>10-2-56</i>			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

MARIETTA STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

Reg. Dist. No.

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
7. MARITAL STATUS		8. OCCUPATION		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. TIME OF DEATH		12. PLACE OF DEATH	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF CORONER		17. SIGNATURE OF JURY		18. SIGNATURE OF JUDGE	

**BUREAU V. S.**

OCT 4 1956

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS AND IS NOT TO BE DESTROYED OR DISPOSED OF IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE REGISTRAR.

9374

CERTIFICATE OF DEATH

09371

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARVE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Long BAR</u>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Virginia</u> Last <u>Longley</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>8</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/9/1867</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Q. Carrell</u>	
14. MOTHER'S MAIDEN NAME <u>Sluss</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Wilhelmina Weidman</u> Address <u>613 Plymouth Rd. Balt., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic C.V.D. Disease</u> <u>422.1</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive pneumonic left</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 8, 1956</u> to <u>Sept 8, 1956</u> , that I last saw the deceased alive on <u>Sept 8, 1956</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Ralph Horkey</u> M.D.		DATE SIGNED <u>Sept 9</u>	
PHYSICIAN'S NAME (Type) <u>J. Ralph Horkey MD</u>		<u>Churchville - Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 12, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McCombs &amp; Son</u>		ADDRESS <u>Abingdon Md.</u>	24a. REC'D BY REGISTRAR <u>DATE 9-14-56</u>
24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>			



CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Faint text]</p>		<p>2. SEX                  [Faint text]</p>	
<p>3. AGE                  [Faint text]</p>		<p>4. DATE OF BIRTH                  [Faint text]</p>	
<p>5. PLACE OF BIRTH                  [Faint text]</p>		<p>6. OCCUPATION                  [Faint text]</p>	
<p>7. MARITAL STATUS                  [Faint text]</p>		<p>8. CAUSE OF DEATH                  [Faint text]</p>	
<p>9. MEDICAL HISTORY                  [Faint text]</p>		<p>10. DATE OF DEATH                  [Faint text]</p>	
<p>11. PLACE OF DEATH                  [Faint text]</p>		<p>12. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
<p>13. SIGNATURE OF REGISTRAR                  [Faint text]</p>		<p>14. SIGNATURE OF WITNESS                  [Faint text]</p>	

BUREAU V. 3

SEP 17 1956

RECEIVED

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09372

9387 **CERTIFICATE OF DEATH**Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Harford</u>			
CITY OR TOWN <u>Bel Air R.D.</u>		LENGTH OF STAY (In this place) <u>Lifetime</u>		CITY OR TOWN <u>Bel Air R.D.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>(Residence on a farm)</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Samuel</u>		(Middle) <u>S.</u>		(Last) <u>Magness</u>			
DATE <u>Sept. 18,</u>		TIME <u>56</u>					
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>married</u>		<b>8. DATE OF BIRTH</b> <u>Nov. 27, 1891</u>	
<b>9. AGE last birthday</b> <u>64</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>    </u> Days <u>    </u>		<b>11. IF UNDER 24 HRS.</b> Hours <u>    </u> Min. <u>    </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Owner</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>							
<b>13. FATHER'S NAME</b> <u>John Thomas Magness</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Irene Knight</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>yes</u> <u>WW 1</u>				<b>16. SOCIAL SECURITY NO.</b> <u>213-36-8748</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>John Henry Magness, Bel Air Md.</u>	
<b>18. MEDICAL CERTIFICATION</b>							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
420.1 IMMEDIATE CAUSE (A) <u>CORONARY OCCLUSION</u> <u>INSTANT</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>CORONARY OCCLUSION 8 years</u> <u>8 yrs</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>ago - on Diurnal for 8 years</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Followed every 2 wks at Mercy Hosp.</u>							
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)				<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from</b> <u>Sept 18, 1956</u> , to <u>Sept 18, 1956</u> , that I last saw the deceased alive on <u>NEVER</u> <u>19</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Philip W. Heuman</u> <u>Deputy Medical Examiner</u>				<b>DATE SIGNED</b> <u>Sept 19, 1956</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Sept. 21, 1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Bel Air Memorial Gardens</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Bel Air, Harford, Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>9-21-56</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Priscilla Fournier</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Howard K. McComas &amp; Son</u>		<b>ADDRESS</b> <u>Abingdon, Md.</u>	

# CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09373

Reg. Dist. No. 185

9375

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) ✓ a. STATE <u>Pa</u> b. COUNTY <u>York</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrods Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>T</u> Last <u>McBride</u>		4. DATE OF DEATH Month <u>September</u> Day <u>30</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/28/34</u>
9. AGE (In years last birthday) <u>22</u> yrs.		10. IF UNDER 1 YEAR Months <u>22</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Liveman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Utility</u>	
11. BIRTHPLACE (State or foreign country) <u>N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Traverse McBride</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Ross</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Ms-Gracie S. S. 1000-10-1000</u>	
17. INFORMANT <u>Ms-Gracie S. S. 1000-10-1000</u>		Address <u>Harrods Grace</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing Injury L. chest</u> 819X DUE TO <u>subcutaneous emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>subcutaneous emphysema</u> DUE TO (c) <u>subcutaneous emphysema</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture R femur</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto-object type</u>	
20c. TIME OF INJURY Month, Day, Year <u>9/29/56</u> Hour <u>8:30</u> a. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>on street</u>		20f. (City or town) <u>Bel Air</u> (County) <u>Harford</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		DATE SIGNED <u>9/30/56</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Harford County</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-2-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CENTRE</u>		22d. LOCATION (City, town, or county) <u>NEW PARK, PA.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Haskins</u>		ADDRESS <u>Delta, Pa.</u>	
24a. REC'D BY REGISTRAR <u>10-2-56</u>		24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files. No burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, occupation, and cause of death. The form is filled out with handwritten text, including "John Doe" and "Heart Disease".

BUREAU V. 2

OCT 4 1956

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9376 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09374

Reg. Dist. No. 185-

ITEM 3:G204 9-21-56L

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Avondale</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford &amp; Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Avondale</u> 75X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>none</u>		d. STREET ADDRESS <u>Rural</u>	
3. NAME OF DECEASED (Type or print) <u>JIMMY</u> First <u>JOHN</u> Middle <u>ANDERS</u> Last <u>McMillan</u>		4. DATE OF DEATH <u>September 10</u> 19 <u>56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/14/1926</u>
9. AGE (In years last birthday) <u>30</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Piney Creek, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>G.F. McMillan</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Burchett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>213-26-604</u>	
17. INFORMANT <u>L.S. Eastham</u> Address <u>Avondale, Pa</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> <u>850.x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell out of boat</u>	
20c. TIME OF INJURY Month, Day, Year <u>4</u> <u>9/10</u> 19 <u>56</u> Hour <u>9</u> a.m. <u>0</u> p.m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Susquehanna River Harford Co. Maryland</u>		20f. (City or town) (County) (State) <u>Harford Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURNAL CREMATION, REMOVAL (Specify) <u>Interment</u>		22b. DATE THEREOF <u>9/13/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fountain Green</u>		22d. LOCATION (City, town, or county) (State) <u>Near Churchville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Scott Eastham</u> ADDRESS <u>Avondale Pa.</u>		24a. REC'D BY REGISTRAR <u>G. L. Eastham</u> DATE <u>9-11-56</u>	
		24b. REGISTRAR'S SIGNATURE <u>G. L. Eastham</u>	

NEW YORK STATE DEPARTMENT OF HEALTH - BALTHAMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		45		M		W		10/10/56		NEW YORK	
RESIDENT OF		CITY		COUNTY		STATE		FEDERAL DISTRICT		CONGRESSIONAL DISTRICT	
NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH	
Clerk		High School		Married		None		Heart Disease		Natural	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF MARRIAGE		NAME OF SPOUSE		NAME OF PHYSICIAN		NAME OF PATHOLOGIST	
10/10/11		NEW YORK		10/10/50		J. J. JONES		J. J. JONES		J. J. JONES	
SIGNATURE OF EXAMINER		TITLE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		FEDERAL DISTRICT		CONGRESSIONAL DISTRICT	
J. J. JONES		Medical Examiner		10/10/56		NEW YORK		NEW YORK		NEW YORK	

RECEIVED  
 SEP 13 1956  
 BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9377

## CERTIFICATE OF DEATH

09375

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN 1b <b>4 Mos</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>200 North Union Ave.</b>		d. STREET ADDRESS <b>North Main St</b>	
3. NAME OF DECEASED (Type or print) <b>John</b> First <b>Howard</b> Middle <b>Pugh</b> Last		4. DATE OF DEATH Month <b>Sept.</b> Day <b>21</b> Year <b>1956</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 29, 1869</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months <b>87</b> Days <b>87</b> Hours <b>87</b> Min.	IF UNDER 24 HRS. Months <b>87</b> Days <b>87</b> Hours <b>87</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Power House</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Howard B. Pugh, 1503 Brandywine Blvd.</b>		Address <b>Wilmington, Del.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial failure - &amp; anemia</b> 902.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fractured humerus -</b> DUE TO (c) <b>Chronic nephritis &amp; anemia -</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day -</b> <b>9 days -</b> <b>5 years -</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I or 19. WAS AUTOPSY PERFORMED? <b>Accidental fall injuring ribs &amp; fracturing left arm at shoulder</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell over door sill</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>11</b> o. ft. <b>Sept 12</b> p. m. <b>1956</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Havre de Grace Harford Maryland</b>	
21. I certify that I attended the deceased from <b>June</b> , 1956, to <b>Sept 21</b> , 1956, that I last saw the deceased alive on <b>Sept 21</b> , 1956, and that death occurred at <b>10:50 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank Wolbert MD</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>Havre de Grace Md 9/21/56</b>	
PHYSICIAN'S NAME (Type) <b>FRANK WOLBERT MD</b>		<b>Havre de Grace, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/24/1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hopewell cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leva Patterson</b>		ADDRESS <b>Perryville, Md.</b>	
24a. REC'D BY REGISTRAR <b>9-23-56</b>		24b. REGISTRAR'S SIGNATURE <b>A. L. Lewis M.D.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		MARRIAGE		EDUCATION		OCCUPATION		RELIGION		RACE		COLOR	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		SYMPTOMS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERGY		SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE		SIGNATURE OF CREMATION	

BUREAU V. S.

SEP 26 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9388 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09376

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. LENGTH OF STAY IN 1b <u>1 yr 25</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RD 1</u>				d. STREET ADDRESS <u>RD 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Clifford</u> Middle <u>Quirkley</u> Last				4. DATE OF DEATH <u>September 24</u> Month <u>24</u> Day <u>1956</u> Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 30, 1955</u>		9. AGE (In years last birthday) <u>1</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Cikerdun Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joshua G. Chickley</u>				14. MOTHER'S MAIDEN NAME <u>Beverly G. Scamion</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Joshua G. Chickley</u> Address <u>Cikerdun Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 27, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Md Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cikerdun Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Taring</u> ADDRESS <u>Cikerdun Md</u>				24a. REC'D BY REGISTRAR <u>Sept 27-56</u>		24b. REGISTRAR'S SIGNATURE <u>Nellie R. Perry</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



SEP 28 1956

1

INSTRUCTIONS

**TO ATTEND PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed in 24 hours after death. The bottom may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 9389 CERTIFICATE OF DEATH

09377

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>Shawsville</u>		LENGTH OF STAY (In this place) <u>22 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Shawsville</u>		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>White Hall R. D.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Heleen A. Richardson</u>				<b>4. DATE OF DEATH</b> (Month) <u>Sept</u> (Day) <u>6</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug 14 1898</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>23</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Elementary</u>		11. BIRTHPLACE (State or foreign country) <u>Norrisville</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Wiley Richardson</u>				14. MOTHER'S MAIDEN NAME <u>Sarah A. Strawbridge</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Mrs. Alice R. Robinson</u> <u>White Hall Rd.</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420.1 IMMEDIATE CAUSE (A) <u>CORONARY OCCLUSION</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>CORONARY INSUFFICIENCY</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>—</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>12 May, 1956</u> , <b>to</b> <u>6 Sept., 1956</u> , <b>that I last saw the deceased alive on</b> <u>6 Sept., 1956</u> , <b>and that death occurred at</b> <u>8:45 A.M.</u> , <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>Thos. O. S. Wootley</u> M.D. <u>Warrentsville, Md.</u> <b>DATE SIGNED</b> <u>6 Sept 1956</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Sept 8 56</u>		NAME OF CEMETERY OR CREMATORY <u>Norrisville Church</u>		LOCATION (City, town, or county) (State) <u>Norrisville Md.</u>	
24. REC'D BY REGISTRAR <u>9-8-56</u>		REGISTRAR'S SIGNATURE <u>Prudella Louwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Martin E. Kutz</u>		ADDRESS <u>Warrentsville</u>	

CERTIFICATE OF DEATH

FILE NO.

LOCAL HEALTH OFFICE

Shawsville

Shawsville

White Hall R. D.

Shawsville

Shawsville

Hele M. Richardson

White

Shawsville

Shawsville

Shawsville

Shawsville

Shawsville

BUREAU V. M.

SEP 11 1956

RECEIVED

Shawsville

Shawsville

Shawsville

## MARYLAND STATE DEPARTMENT OF HEALTH

9390

2411 N. Charles Street, Baltimore

09378

## CERTIFICATE OF DEATH

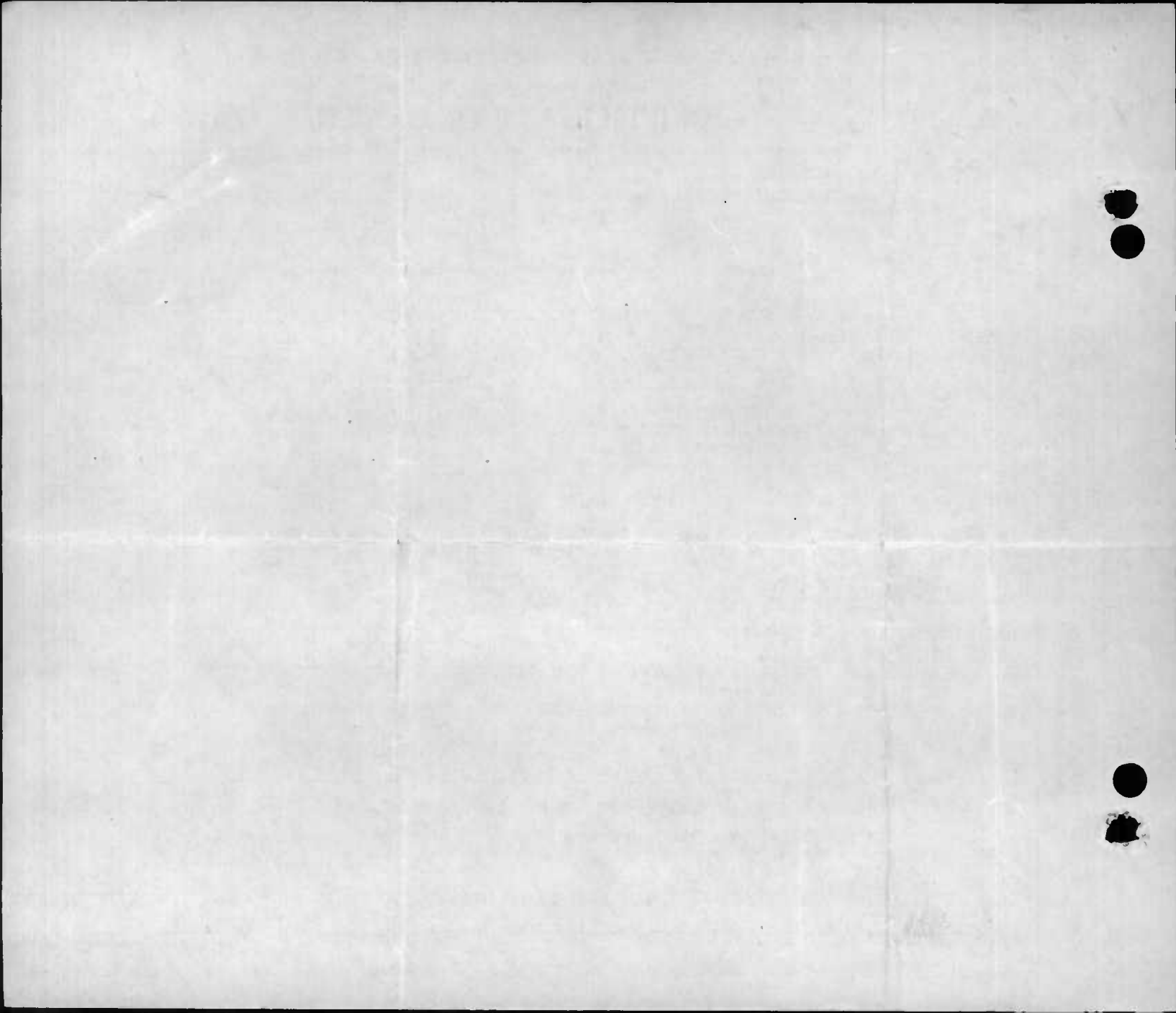
Reg. Dist. No.....

1. PLACE OF DEATH- COUNTY Harford		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Perryman		CITY (If outside corporate limits, write RURAL and give nearest town) Perryman	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) John	(Middle) J.	(Last) Ruane
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH July 11, 1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 81 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Ruane		14. MOTHER'S MAIDEN NAME Cecilia T. Cummings	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Mr. Joseph H. Nelson		Perryman, Md.	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
443 X Immediate cause (a) <i>Arterio Sclerotic Cardio Vascular</i>			
Antecedent cause(s) (b) <i>Hypertension, Hypertrophy Prostate</i>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Calcemia</i>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June, 1956, to Sept 1956, that I last saw the deceased alive on Sept 10, 1956, and that death occurred at 513 m., from the causes and on the date stated above.			
SIGNATURE <i>Charles J. Foley M.D.</i>		ADDRESS <i>444 N. Morgan Ave. Baltimore, Md 9/19/56</i>	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF Sept. 13, 1956	
NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		LOCATION (City, town, or county) Baltimore, Md	
DATE REC'D BY LOCAL REG. 9-11-56		REGISTRAR'S SIGNATURE <i>W. H. Meason</i>	
		FEDERAL DIRECTOR ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





9391

CERTIFICATE OF DEATH

09379

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		c. LENGTH OF STAY IN 1b <b>9 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US Army Hospital</b>		d. STREET ADDRESS <b>302 Old Post Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Walter</b> Last <b>Shaffer</b>		4. DATE OF DEATH Month <b>September</b> Day <b>5</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 8 1955</b>
9. AGE (In years last birthday) yrs. <b>8</b> Months <b>28</b>		IF UNDER 1 YEAR <b>8</b> Months <b>28</b> Days <b>28</b> Hours <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Joseph Shaffer</b>		14. MOTHER'S MAIDEN NAME <b>Georgenia Dott Erickson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mother</b>		Address <b>(same as in 2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 759.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fibrocystic disease</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>from birth</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 4</b> , 19 <b>56</b> , to <b>Sept 5</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Sept 5</b> , 19 <b>56</b> , and that death occurred at <b>8:05 a.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Hurdon Augustson</b> M.D.		DATE SIGNED <b>Sept 5, 1956</b>	
PHYSICIAN'S NAME (Type) <b>HREIDAR A GUSTSSON, Major, MC</b>		ADDRESS (Street, city or town, state) <b>US Army Hospital Aberdeen Proving Ground, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>9/5/56</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>Jamestown New York</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John E. Sarring</b> ADDRESS <b>Aberdeen Maryland</b>		24a. REC'D BY REGISTRAR <b>Sept 7-56</b> 24b. REGISTRAR'S SIGNATURE <b>Nellie G Perry</b>	

2050243385

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
Robert Joseph Butler		10-10-1956		BALIKPAPAN	
AGE		SEX		OCCUPATION	
70		Male		None	
DATE OF BIRTH		PLACE OF BIRTH		NATIONALITY	
10-10-1886		BALIKPAPAN		American	
MARITAL STATUS		RELIGION		EDUCATION	
Married		Catholic		High School	
NAME OF SPOUSE		NAME OF CHILDREN		NAME OF NEXT OF KIN	
None		None		None	
CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF REGISTRAR	
Thrombotic disease		Natural		[Signature]	
DATE OF REPORT		REPORTED BY		OFFICIAL SEAL	
10-10-1956		[Signature]		[Seal]	

BUREAU V. 2

SEP 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>	
		d. STREET ADDRESS <u>212 S. Freedom St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>—</u> Last <u>Stansbury</u>		4. DATE OF DEATH Month <u>September</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10th 1883</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Isaac Stansbury</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Wm. Stansbury</u>		Address <u>Harford Grace</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Metastatic Carcinoma of Prostate</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 14, 1956</u> to <u>Sept. 14, 1956</u> , that I last saw the deceased alive on <u>Sept. 14, 1956</u> , and that death occurred at <u>10:40 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		ADDRESS (Street, city or town, state) <u>569 Revolution St., Harford Grace, Md.</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		DATE SIGNED <u>9/14/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/17/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union W. E. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Fanning</u>		ADDRESS <u>Aberdeen Md.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Hansen</u>	
DATE <u>9-17-56</u>			

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## CERTIFICATE OF DEATH

8078

NAME OF DECEASED		DATE OF DEATH	
MAYNARD		1956	
AGE		SEX	
100		M	
RACE		EDUCATION	
W		H	
OCCUPATION		CAUSE OF DEATH	
C		H	
PLACE OF DEATH		DATE OF BURIAL	
H		H	
NAME OF PHYSICIAN		NAME OF FUNERAL HOME	
H		H	
SIGNATURE OF DECEASED		SIGNATURE OF PHYSICIAN	
H		H	
DATE OF SIGNATURE		DATE OF SIGNATURE	
H		H	

BUREAU V. 8

SEP 19 1956

RECEIVED

9379

## CERTIFICATE OF DEATH

Reg. Dist. No.

185-

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARTFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>				c. LENGTH OF STAY IN 1b <u>4 1/2 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hosp.</u>				d. STREET ADDRESS <u>R.F.D. 1 Box 47</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Tazwell</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 9, 1901</u>	
9. AGE (In years lost birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>35</u> Days <u>35</u> Hours <u>35</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Columbus, N.C.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>DAVID SMITH</u>				14. MOTHER'S MAIDEN NAME <u>Cornelius Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Howard Tazwell</u> Address <u>Havre de Grace</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Hypertensive Arteriosclerotic Heart disease</u> DUE TO (c) <u>Hypertensive Arteriosclerotic Heart disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>4/8</u> <u>1956</u>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4/8</u> , 19 <u>56</u> to <u>9/29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/29</u> , 19 <u>56</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>569 Revolution St., Havre de Grace, Md.</u> DATE SIGNED <u>10/1/56</u>							
ACTUAL SIGNATURE <u>George T. Stansbury, M.D.</u>							
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u> <u>Havre de Grace, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-3-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Otelia G. Bullock - Havre de Grace, Md.</u> ADDRESS <u>2nd</u>							
24a. REC'D BY REGISTRAR <u>A. L. Lewis M.D.</u> DATE <u>10-2-56</u>							
24b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		MANNER OF DEATH	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		RELIGION	
MARITAL STATUS		PREVIOUS ILLNESS	
CAUSE OF DEATH		IMMEDIATE CAUSE	
MEDICAL HISTORY		PATHOLOGICAL FINDINGS	
TREATMENT		POST-MORTEM EXAMINATION	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
DATE		PLACE	

BUREAU V. S.

OCT 4 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-front permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

9380 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) <input checked="" type="checkbox"/> o. STATE <b>PENN</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harrode Grace</b>		c. LENGTH OF STAY IN 1b <b>NONE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>B + O. RR Tracks</b>		d. STREET ADDRESS <b>529 W Franklin St</b>	
3. NAME OF DECEASED (Type or print) <b>Clarence Jack Travis</b>		4. DATE OF DEATH <b>September 27 1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH (Approx) <b>22</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Evisceration Cerebrum</b> 802x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>-</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Compound comminuted fracture nearly every bone in body</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by train while walking on RR Tracks</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>7 Sept 24 1956</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>B + O RR Tracks Harrode Grace Harford Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Gerald C Palmer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Gerald C Palmer M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <b>Harford County</b>		DATE SIGNED <b>9/27/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>9/28/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. James</b>	22d. LOCATION (City, town, or county) (State) <b>Harrode Grace Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William J. R. Harrode Grace, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>9-28/56</b>		24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9381

## CERTIFICATE OF DEATH

09383

Reg. Dist. No.

185-

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>CECIL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAUCE DE GRACE</b>		c. LENGTH OF STAY IN 1b <b>5 HRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL HOSP.</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MABEL CATHERINE WEIR</b>		4. DATE OF DEATH Month Day Year <b>SEPT. 26 1956</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 12, 1882</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.S.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE W GRAYSON</b>		14. MOTHER'S MAIDEN NAME <b>RACHEL IRVIN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Harry Weir Rising Sun, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> DUE TO <b>Coronary Arteriosclerosis</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>24 hr.</b> <b>24 hr.</b> <b>5 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260x Diabetes Mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>9-25-56</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-25-56</b> , to <b>9-26-56</b> , that I last saw the deceased alive on <b>9-25-56</b> , and that death occurred at <b>12:35</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Peter P. Rodman, M.D.</b>		DATE SIGNED <b>9-26-56</b>	
PHYSICIAN'S NAME (Type) <b>Peter P. Rodman, M.D.</b>		<b>Aberdeen, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 28, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Brookview Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Rising Sun, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Earl Taylor</b>		ADDRESS <b>Rising Sun, Md.</b>	
24a. REC'D BY REGISTRAR <b>U. L. Keenan</b>		24b. REGISTRAR'S SIGNATURE <b>U. L. Keenan</b>	

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

10-1885

BUREAU V. S.

OCT 1 1956

RECEIVED

10-1885

10-1885



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9382

CERTIFICATE OF DEATH

09384

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Route #2</u>	
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>Mary</u> Last <u>Wilmer</u>		4. DATE OF DEATH Month <u>September</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 28, 1871</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Samuel Jones</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Chase</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mary B. Gilbert</u>		Address <u>Magnolia Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Coronary Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>10 yr.</u> <u>10 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Stomach with Metastasis to Liver</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 24</u> , 1956, to <u>Sept 28</u> , 1956, that I last saw the deceased alive on <u>Sept 28, 1956</u> at <u>8:35</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter P. Rodman</u> M.D.		ADDRESS (Street, city or town, state) <u>Law St. Abingdon, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman M.D.</u>		DATE SIGNED <u>9-28-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 30, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Magnolia, Harford Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Mc Comas &amp; Son</u>		ADDRESS <u>Abingdon Maryland</u>	
24a. REC'D BY REGISTRAR <u>Oct 3-56</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

CERTIFICATE OF DEATH

3252

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF DECEASED [Faint text]	
SIGNATURE OF NEXT OF KIN [Faint text]		SIGNATURE OF BURIAL OFFICIAL [Faint text]	
SIGNATURE OF FUNERAL HOME [Faint text]		SIGNATURE OF CHURCH OFFICIAL [Faint text]	
SIGNATURE OF MINISTER [Faint text]		SIGNATURE OF OTHER [Faint text]	

BUREAU V. 8

OCT 4 1956

RECEIVED